STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELSIE-DORIS FAMILY CARE HOME	306 CHERRYGROVE STREET DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 04/29/21 and 04/30/21 with a telephone exit on 04/30/21.	C 000		
C 186	10A NCAC 13G .0601 (b)(1) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used: (1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home; This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure 1 of 1 resident (#1) was not left alone in the facility without staff supervision.	C 186		

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C 186	Continued From page 1 The findings are: Observation of the facility on 04/29/21 at 9:25am revealed: -At 9:25am the facility's front door was wide open. -At 9:32am a resident came outside the facility and sat on the front porch. -At 9:34am the Supervisor-in-Charge (SIC) was observed crossing the street in front of the facility and entering the facility. Interview with the SIC on 04/29/21 at 9:40am revealed: -There was no other staff working at the facility, but her. -She left residents alone when she had to run errands. -She had been told if she was within 500 feet of the facility, she was able to leave residents alone in the facility. -She had gone to the local hospital to make an appointment for another resident. -She was unable to recall how long Resident #1 was left alone but thought it was less than 30 minutes. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed: -When she opened the facility in 2008, a surveyor told her that she could leave residents alone in the house if she was within 500 feet away. -Sometimes the SIC's male friend (live-in boyfriend) stayed in the house with the residents when the SIC left the facility. -The SICs male friend was not an employee of the facility and she had not completed a staff record on him. Review of Resident #1's current FL2 dated	C 186		

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C 186	Continued From page 2 07/23/20 revealed: -Diagnoses included schizophrenia and borderline intellectual disability. -Resident #1 was constantly disoriented. Review of Resident #1's care plan dated 03/25/20 revealed the resident was independent with all activities of daily living. Based on observation, record review, and interview, it was determined Resident #1 was not interviewable.	C 186		
C 207	10A NCAC 13G .0702(c)(4) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to contact the physician for clarification of incomplete information on the residents' FL2s for 3 of 3 sampled residents (#1, #2 and #3). The findings are:	C 207		

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C 207	Continued From page 3 1. Review of Resident #1's current FL2 dated 07/23/20 revealed: -Diagnoses included schizophrenia, borderline intellectual disabled. -There were no medications listed on the FL2. -There was a handwritten note "see list" under "Medications" on the FL2. -There was no list attached to the FL2. Review of Resident #1's April 2021 medication administration record (MAR) revealed: -There was an entry for haloperidol 10mg (an antipsychotic used to treat behaviors) once daily scheduled for administration at 8:00am. -There was documentation haloperidol 10mg was administered from 04/01/21 through 04/30/21. -There was an entry for omeprazole 20mg (used to treat acid reflux) once daily scheduled for administration at 8:00am. -There was documentation omeprazole 20mg was administered from 04/01/21 through 04/28/21. -There was an entry for combigan 0.2% eye drops (used to treat high pressure in the eyes due to glaucoma) twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation combigan eye drops were administered from 04/01/21 through 04/31/21 (actual documentation). -There was an entry for quetiapine 50mg (an antipsychotic used to treat schizophrenia) twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation quetiapine 50mg was administered twice daily 04/01/21 through 04/29/21. -There was an entry for atorvastatin 10mg (an antihyperlipidemic used to treat high cholesterol levels) at bedtime scheduled for administration at	C 207		

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C 207	Continued From page 4 8:00pm. -There was no documentation atorvastatin 10mg was administered. Observation of Resident #1's medications on hand at the facility on 04/29/21 at 11:56am revealed: -Haloperidol 10mg was available for administration. -Omeprazole 20mg was available for administration. -Combigan 0.2% eye drops were not available for administration. -Atorvastatin 10mg was not available for administration. -Quetiapine 50mg was available for administration. Telephone interview with Resident #1's mental health provider on 04/30/21 at 4:21pm revealed: -Currently, Resident #1 had orders for two psychotropic medications, and that was Haldol 100mg injection every four weeks, and viutrol 280 via injection every four weeks. -The haldol 10mg was discontinued a long time ago. -The facility should have contacted him if they had questions about the haldol. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56pm was unsuccessful. Based on record review, observations and interview, it was determined that Resident #1 was not interviewable. Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm.	C 207		

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C 207	Continued From page 5 Refer to telephone interview with the Administrator on 04/29/21 at 11:29am. 2. Review of Resident #2's current FL2 dated 12/26/20 revealed: -Diagnoses included hypertension, mild intellectual disability, schizoaffective disorder, hyperlipidemia. -Resident #2 was constantly disoriented. -There were no medications listed on the FL2. -There was a handwritten note "see attached list" under "Medications" on the FL2. -There was no list attached to the FL2 with medications. Review of Resident #2's April 2021 medication administration record (MAR) revealed: -There was an entry for amlodipine 10mg (used to treat high blood pressure) once daily was scheduled for administration at 8:00am. -There was documentation amlodipine 10mg was administered once daily from 04/01/21 through 04/31/21 (actual documentation with 31 days). -There was an entry for aripiprazole 30mg (used to treat mental/mood disorders) once daily scheduled for administration at 8:00am. -There was documentation aripiprazole 30mg was administered once daily from 04/01/21 through 04/31/21. -There was an entry for aspirin 81mg (used to treat mild pain/fever and thins the blood) once daily scheduled for administration at 8:00am. -There was documentation aspirin 81mg was administered once daily from 04/01/21 through 04/31/21. -There was an entry for clonazepam 1mg (an antiepileptic agent used to treat seizures) once daily scheduled for administration at 8:00am. -There was documentation clonazepam 1mg was administered once daily from 04/01/21 through	C 207		

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C 207	Continued From page 6 04/31/21. -There was an entry for fluticasone 50mcg (used to relieve symptoms of hay fever and other allergies) 1 to 2 sprays into both nostrils once daily was scheduled for administration at 8:00am. -There was documentation fluticasone 50mcg was administered once daily from 04/01/21 through 04/31/21. -There was an entry for hydrochlorothiazide 12.5mg once daily was scheduled for administration at 8:00am. -There was documentation hydrochlorothiazide 12.5mg (a thiazide diuretic used to treat high blood pressure) was administered once daily from 04/01/21 through 04/31/21. -There was an entry for isosorbide extended release 60mg (an osmotic diuretic used to treat glaucoma) once daily scheduled for administration at 8:00am. -There was documentation isosorbide 60mg was administered once daily from 04/01/21 through 04/31/21. -There was an entry for lithium carbonate 300mg (an antimanic agent used to treat manic episodes) 2 capsules (600mg) once daily scheduled for administration at 8:00am. -There was documentation lithium carbonate 600mg was administered once daily from 04/01/21 through 04/31/21. -There was an entry for multi vite tablets (vitamin supplements)once daily scheduled for administration at 8:00am. -There was documentation multi vite was administered once daily from 04/01/21 through 04/31/21. -There was an entry for pantoprazole 20mg (used to treat acid reflux) once daily scheduled for administration at 8:00am. -There was documentation pantoprazole 20mg was administered once daily from 04/01/21	C 207		

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through 04/31/21.
-There was an entry for potassium extended release 8 meq (used to treat low potassium levels) 2 tablets (16 meq) once daily scheduled for administration at 8:00am.
-There was documentation potassium 16 meq was administered once daily from 04/01/21 through 04/31/21.
-There was an entry for Pravastatin 40mg (used to treat high cholesterol levels) once daily scheduled for administration at 8:00pm.
-There was documentation Pravastatin 40mg was administered once daily from 04/01/21 through 04/31/21.
-There was an entry for vitamin B-12 (used to treat low vitamin B-12 levels) once daily scheduled for administration at 8:00am.
-There was documentation vitamin B-12 was administered once daily from 04/01/21 through 04/31/21.
-There was an entry for benztropine 0.5mg (used to treat Parkinson's disease) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation benztropine 0.5mg was administered daily at 8:00am from 04/01/21 through 04/31/21.
-There was no documentation benztropine 0.5mg was administered at 8:00pm from 04/01/21 through 04/31/21.
-There was an entry for metoprolol 25mg (used to treat high blood pressure) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered once daily at 8:00am from 04/01/21 through 04/31/21.
-There was no documentation metoprolol 25mg was administered at 8:00pm from 04/01/21 through 04/31/21.
-There was an entry for fish oil 1000mg (used to

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treat and manage heart disease and lower blood pressure) three times daily scheduled for administration at 8:00am 2:00pm and 8:00pm.
-There documentation fish oil was administered at 8:00am from 04/01/21 through 04/31/21.
-There was no documentation fish oil was administered at 2:00pm and 8:00pm from 04/01/21 through 04/31/21.
-There was an entry for melatonin 1mg (used to treat insomnia) at bedtime scheduled for administration at 8:00pm.
-There was documentation melatonin 1mg was administered daily 04/01/21 through 04/31/21.
-There was an entry for quetiapine 25mg (an antipsychotic used to treat schizophrenia) once daily at bedtime scheduled for administration at 8:00pm.
-There was documentation quetiapine 25mg was administered once daily at bedtime from 04/01/21 through 04/31.

Observation of Resident #2's medications on hand at the facility on 04/29/21 at 11:58am revealed:
-Amlodipine 10mg was available for administration.
-Aripiprazole 30mg was available for administration.
-Aspirin 81mg was available for administration.
-Clonazepam 1mg was available for administration.
-Fluticasone 50mcg was not available for administration.
-Hydrochlorothiazide 12.5mg was available for administration.
-Isosorbide extended release 60mg was not available for administration.
-Lithium carbonate 600mg was available for administration.
-Multi vite tablets was not available for

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administration.
-Pantoprazole 20mg was available for administration.
-Potassium extended release 8 meq 2 tablets (16 meq) was available for administration.
-Pravastatin 40mg was available for administration.
-Vitamin B-12 once daily was available for administration.
-Benztropine was available for administration.
-Metoprolol was available for administration.
-Fish oil was available for administration.
-Melatonin was not available for administration.
-Quetiapine was available for administration.

Telephone interview with the facility's contracted pharmacy on 04/30/21 at 11:45am revealed:
-Resident #2's medications were cycle filled each month.
-The pharmacy had current orders for most of Resident #2's medications.
-The pharmacy did not have current orders for over-the-counter medications such as B-12, last filled on 08/02/18; fish oil, last filled on 08/16/19; melatonin lasts filled on 08/18/18; multi-vitamin, last filled on 10/17/17; aspirin last filled on 12/19/18; fluticasone 50mcg, last filled on 12/20/18; and isosorbide extended-release, last filled on 08/16/19.
-The facility did not purchase these medications through the pharmacy but over-the-counter (OTC) to save money.
-The OTC medications not dispensed by the pharmacy were printed on the MAR for documentation purposes.
-Other medications not dispensed by the pharmacy included fluticasone, isosorbide and melatonin.

Attempted interview with Resident #2 on 04/30/21

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at 9:38am was unsuccessful.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 04/30/21 at 4:37pm was unsuccessful.

Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm.

Refer to telephone interview with the Administrator on 04/29/21 at 11:29am.

3. Review of Resident #3's current FL2 dated 10/22/20 revealed:
-Diagnoses included schizoaffective disorder, depression, and dysphoria.
-There were no medications listed on the FL2.
-There was a handwritten note "see attachment" under the "medications" of the FL2.
-There were no documents attached to the FL2.
-There was no updated medication list in Resident #3's record.

Review of Resident #3's April 2021 medication administration record (MAR) revealed:
-There was an entry for alendronate 70mg (used to treat and prevent osteoporosis) once a week scheduled for administration weekly.
-There was documentation alendronate 70mg was administered once daily from 04/01/21 through 04/29/21.
-There was an entry for benztropine 1mg (used to treat Parkinson's disease) once daily scheduled for administration at 8:00am.
-There was no documentation benztropine 1mg was administered.
-There was an entry for enulose solution 20gm (used to treat liver disease) once daily scheduled for administration at 8:00am.
-There was documentation enulose solution

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C 207	Continued From page 11 20mg was administered once daily from 04/01/21 through 04/30/21. -There was an entry for olanzapine 15mg (used to treat mental/mood disorders) once daily was scheduled for administration at 8:00am. -There was documentation olanzapine 15mg was administered once daily from 04/01/21 through 04/30/21. -There was an entry for omeprazole 20mg (used to treat acid reflux) once daily was scheduled for administration at 8:00am. -There was documentation omeprazole 20mg was administered once daily from 04/01/21 through 04/30/21. -Polyethylene glycol 3350 powder 17gm (used to treat constipation) once daily was scheduled for administration at 8:00am. -There was documentation polyethylene glycol 3350 powder 17gm was administered once daily from 04/01/21 through 04/30/21. -There was an entry for venlafaxine extended release 75mg (used to treat depression) take 3 capsules (150mg) once daily scheduled for administration at 8:00am. -There was documentation venlafaxine 150mg was administered once daily from 04/01/21 through 04/30/21. -There was an entry for acetaminophen 325mg (used to treat mild pain/fever) 2 tablets (650mg) three times daily scheduled for administration at 8:00am, 2:00pm and 8:00pm. -There was documentation acetaminophen 650mg was administered three times daily from 04/01/21 through 04/06/21. -There was documentation acetaminophen 650mg was administered once daily from 04/07/21 through 04/30/21. -There was an entry for enoxaparin 80mg (an anticoagulant that helps prevent the formation of blood clots) subcutaneously every 12 hours	C 207		

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scheduled for administration at 8:00am and 8:00pm.
-There was documentation enoxaparin 80mg was administered once daily from 04/01/21 through 04/30/21.
-There was an entry for gabapentin 300mg (used to treat seizures and nerve pain) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation gabapentin 300mg was administered once daily from 04/01/21 through 04/30/21.
-There was an entry for senexon-S (used to treat constipation) twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation senexon-S was administered.
-There was an entry for tamsulosin 0.4mg (used to treat symptoms of enlarge prostate) at bedtime scheduled for administration at 8:00pm.
-There was documentation tamsulosin 0.4mg was administered once daily from 04/01/21 and 04/30/21.

Observation of Resident #3's medications on hand at the facility on 04/29/21 at 11:59am revealed:
-Alendronate 70mg was not available for administration
-Benztropine 1mg was available for administration
-Enulose solution 20gm was not available for administration
-Olanzapine 15mg was available for administration
-Omeprazole 20mg was not available for administration
-Polyethylene glycol 3350 powder 17gm was not available for administration
-Venlafaxine extended release 75mg was not

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ELSIE-DORIS FAMILY CARE HOME	306 CHERRYGROVE STREET DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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available for administration
-Acetaminophen 325mg was available for administration
-Acetaminophen 650mg was available for administration
-Enoxaparin 80mg was not available for administration
-Gabapentin 300mg was available for administration
-Senexon-S was not available for administration
-Tamsulosin 0.4mg

Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/30/21 at 9:18am revealed:
-Resident #3's current medications included:
-Benztropine 1mg once daily
-Gabapentin 300mg twice daily
-Olanzapine 15mg once daily
-Omeprazole 20mg once daily
-Invega injection once per month
-Metamucil 3.4gm once daily with a glass of fluid.
-If Resident #3 was administered other medications they were not ordered by the PCP.

Telephone interview with the facility's contracted pharmacy on 04/30/21 at 11:16am revealed:
-The pharmacy filled Resident #3's medications every month.
-The last order received for benztropine 1mg once daily dated 09/17/20.
-The medication was last filled and dispensed on 04/26/21 for a quantity of 30 tablets.
-There was an order for omeprazole 20mg once daily dated 09/08/20.
-The medication was last filled and dispensed on 03/30/21 for a quantity of 30 tablets.
-There was an order for gabapentin twice daily dated 04/02/21.
-The medication was filled and dispensed on

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C 207	Continued From page 14 04/02/21 for a quantity of 60 tablets. -There was an order for olanzapine 15mg once daily dated 04/28/21. -Olanzapine 15mg was filled and dispensed on 04/28/21 for a quantity of 30 tablets. -There were no orders for alendronate 70mg once a week, enulose solution 20gm once daily, polyethylene glycol 3350 powder 17gm once daily, venlafaxine extended release 75mg take 3 capsules (150mg) once daily, acetaminophen 325mg 2 tablets (650mg) three times daily, enoxaparin 80mg subcutaneously every 12 hours, senexon-S twice daily and tamsulosin 0.4mg at bedtime. Attempted interview with Resident #3 on 04/29/21 at 9:40am was unsuccessful. Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm. Refer to telephone interview with the Administrator on 04/29/21 at 11:29am. _____ Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm. -She did not know the current medications ordered for the residents. -When FL2s were signed by the PCP they sometimes wrote "see attached list or see attached" but often did not attach a medication list. -She did not contact the PCP to obtain a list of the current medications. -She administered medications based on the medications received from the pharmacy because the pharmacy had the current orders. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed:	C 207		

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C 207	Continued From page 15 -She did not know why residents had FL2s that referred to an attached medication list when there was no list. -If the PCP documented "see attached list" the PCP always provided an attached list of medications. -When the FL2 came from the PCP there was a list of medications attached. -Evidently, the SIC had taken the paperwork out of the residents' records. -She expected the SIC to go through the residents' records and make sure everything was in the record. -The SIC should be going through the records at least once per month. -She had not been to the facility like she was supposed to be.	C 207		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure blood pressure (BP) checks were implemented and documented as ordered for 1 of 3 sampled residents (Resident #2) with orders for weekly BP checks. The findings are:	C 249		

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C 249	Continued From page 16 Review of Resident #2's current FL2 dated 12/26/20 revealed diagnoses included hypertension, mild intellectual disability, schizoaffective disorder and hyperlipidemia. -There was an order for weekly BP monitoring. Review of Resident #2's March 2021 medication administration record (MAR) revealed: -There was an entry to check BP and record weekly. -There were no documented BP readings on the MAR from 03/01/21 through 03/31/21. Review of Resident #2's April 2021 MAR revealed: -There was an entry to check BP and record weekly. -There were no documented BP readings on the MAR from 04/01/21 through 04/29/21. Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:50pm revealed: -When an FL2 was returned by the Primary Care Provider (PCP) she received the FL2 and filed it in the resident's record. -She did not review the FL2. -She did not know Resident #2 was ordered weekly BP checks. -She did not check Resident #2's BP weekly. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed: -She expected the SIC to follow the orders on the FL2 and check the resident's BP as ordered by the PCP. -She did not know Resident #2 had and order for weekly BP. -She had not reviewed Resident #2's current FL2. -The SIC was responsible for checking the	C 249		

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C 249	Continued From page 17 residents' records daily and ensuring PCP orders were implemented. Attempted interview with Resident #2 on 04/29/21 at 9:38am was unsuccessful. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 04/30/21 at 4:37pm was unsuccessful.	C 249		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to contact the Primary Care Provider (PCP) for 1 of 3 sampled residents (Resident #1) for clarification of orders related to a antipsychotic medications, a proton pump inhibitor, cholesterol medication, and an eye drop. The findings are:	C 315		

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C 315	Continued From page 18 Review of Resident #1's current FL2 dated 07/23/20 revealed: -Diagnoses included schizophrenia and borderline intellectual disability. -There were no medications listed on the FL2. -There was a handwritten note "see list" under "Medications" on the FL2. -There was no list attached to the FL2. a. Review of Resident #1's previous FL2 dated 07/23/20 revealed medication orders included aripiprazole 7.5mg once daily (used to treat schizophrenia). Review of Resident #1's March 2021 medication administration record (MAR) revealed there was no entry for aripiprazole 7.5mg once daily. Review of Resident #1's April 2021 MAR revealed there was no entry for aripiprazole 7.5mg once daily. Observation of Resident #1's medications on hand on 04/29/21 at 11:56am revealed aripiprazole 7.5mg was not available for administration. Based on observation, record review and interview, it was determined Resident #1 was not interviewable. Refer to interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm. Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am. Refer to the telephone interview with a representative from the facility's contracted	C 315		

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pharmacy on 04/30/21 at 11:16am.

b. Review of Resident #1's previous FL2 dated 07/23/20 revealed there was a medication order for omeprazole 20mg once daily (used to treat acid reflux).

Review of Resident #1's March 2021 medication administration record (MAR) revealed:
-There was an entry for omeprazole 20mg once daily scheduled for administration at 8:00am.
-There was no documentation omeprazole 20mg was administered.

Review of Resident #1's April 2021 MAR revealed:
-There was an entry for omeprazole 20mg once daily.
-There was documentation omeprazole 20mg was administered once daily from 04/01/21 through 04/28/21.

Observation of Resident #1's medications on hand on 04/29/21 at 11:56am revealed omeprazole 20mg was available for administration.
-There were two bubble-packed containers of omeprazole 20mg.
-One bubble packed container was dispensed on 02/25/20 for a quantity of 30 capsules with 22 omeprazole capsules remaining.
-The second bubble-packed container was dispensed on 10/14/19 for a quantity of 30 tablets with 19 omeprazole capsules remaining.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56pm was unsuccessful.

Based on observation, record review and

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interview, it was determined Resident #1 was not interviewable.

Refer to interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm.

Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am.

c. Review of Resident #1's previous FL2 dated 07/23/20 revealed there was a medication order for quetiapine 50mg twice daily (used to treat schizophrenia).

Review of Resident #1's March 2021 medication administration record (MAR) revealed:
-There was an entry for quetiapine 50mg twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation quetiapine 50mg was administered twice daily from 03/01/21 through 03/31/21.

Review of Resident #1's April 2021 MAR revealed:
-There was an entry for quetiapine 50mg twice daily.
-There was documentation quetiapine 50mg was administered twice daily from 04/01/21 through 04/30/21.

Observation of Resident #1's medications on hand on 04/29/21 at 11:56am revealed quetiapine 50mg was available for administration.
-Quetiapine 50mg was filled on 12/16/19 and a quantity of 60 tablets was dispensed.

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C 315	Continued From page 21 -The bubble-packed container was unopened and there were 60 tablets remaining. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56pm was unsuccessful. Based on observation, record review and interview, it was determined that Resident #1 was not interviewable. Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm. Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am. d. Review of Resident #1's previous FL2 dated 07/23/20 revealed there was a medication order for atorvastatin 10mg at bedtime (used to treat high cholesterol). Review of Resident #1's March 2021 medication administration record (MAR) revealed: -There was an entry for atorvastatin 10mg at bedtime scheduled for administration at 8:00pm. -There was no documentation atorvastatin 10mg was administered from 03/01/21 through 03/31/21. Review of Resident #1's April 2021 MAR revealed there was no entry for atorvastatin 10mg on the MAR. Observation of Resident #1's medications on hand on 04/29/21 at 11:56am revealed	C 315		

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atorvastatin 10mg was not available for administration.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56pm was unsuccessful.

Based on observation, record review, and interview, it was determined Resident #1 was not interviewable.

Refer to interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm.

Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am.

e. Review of Resident #1's previous FL2 dated 07/23/20 revealed there was a medication order for combigan 0.2% eye drops in both eyes daily (used to treat ocular hypertension).

Review of Resident #1's March 2021 medication administration record (MAR) revealed:
-There was an entry for combigan 0.2% eye drops in both eyes twice daily scheduled for administration at 8:00am and 8:00pm.
-There was no documentation combigan 0.2% was administered from 03/01/21 through 03/31/21.

Review of Resident #1's April 2021 MAR revealed:
-There was an entry for combigan 0.2% eye drops in both eyes twice daily scheduled for administration at 8:00am and 8:00pm.

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C 315	Continued From page 23 -There was documentation combigan 0.2% was administered twice daily from 04/01/21 through 04/29/21. Observation of Resident #1's medications on hand on 04/29/21 at 11:56am revealed combigan 02% was not available for administration. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56pm was unsuccessful. Based on observation, record review and interview, it was determined Resident #1 was not interviewable. Refer to interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm. Refer to the telephone interview with the Administrator on 04/29/21 at 11:29am. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am. _____ Interview with the SIC on 04/29/21 at 12:30pm revealed: -She administered Resident #1's medications daily. -She administered medications that were sent to the facility from the pharmacy. -She did not know Resident #1 had medications on the MAR that were not available in the facility. -The facility used three different pharmacy's and she did not know which pharmacy filled Resident #1's medications. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed:	C 315		

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C 315	Continued From page 24 -She expected the SIC to check the residents' records daily to ensure medications on hand matched current orders. -She had not been at the facility much lately. -The SIC knew she had to contact the PCP if she was not sure about a medication order. Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed: -The pharmacy had not filled Resident #1's medications for over one year. -In May 2020, the pharmacy filled one medication for Resident #1. -Prior to May 2020, the pharmacy had not filled medications for Resident #1 since December 2019. -The facility must be using another pharmacy to fill Resident #1's medications. -This pharmacy was not providing MARs to the facility for Resident #1's medications.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION	C 330		

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Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to an anticoagulant injection, an antibiotic ointment, a pain medication and a powdered laxative (#1), a proton pump inhibitor, nerve pain and muscle spasms medications (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 07/26/20 revealed:
-Diagnoses included schizophrenia and borderline intellectual disability.
-Resident #1 was constantly disoriented.

a. Review of Resident #1's hospital discharge summary report dated 04/23/21 revealed:
-Resident #1 was hospitalized from 04/14/21 through 04/23/21.
-Resident #1 had a car accident and sustained a broken hip.
-Resident #1 had surgery to repair the broken hip.
-The discharge summary included a medication order for Lovenox (used to thin the blood) with instructions to inject 40mg subcutaneously once daily for 21 days to prevent blood clots resulting from the surgery.
-There were instructions to start Lovenox 40mg on 04/24/21 and stop the Lovenox on 05/08/21.

Review of Resident #1's April 2021 medication administration record (MAR) revealed there was no entry for Lovenox on the MAR.

Observation of Resident #1's medications on hand at the facility 04/29/21 at 11:56am revealed:
-Lovenox 40mg was available for administration.

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C 330	Continued From page 26 -There were four vials of Lovenox unopened. -Lovenox was dispensed on 04/28/21. Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed: -The facility sent the pharmacy the order for Resident #1's Lovenox on 04/23/21. -The pharmacy had not filled Resident #1's medication for over one year, so he did not know what to do with the orders. -On 04/28/21, "someone" from the facility called and asked about Resident #1's medications, then said "O, I sent that to the wrong pharmacy." -The pharmacy filled the order for Lovenox and the medication was delivered to the facility on 04/28/21. Telephone interview with Resident #1's guardian on 04/30/21 at 9:08am revealed: -Earlier in the month Resident #1 was hit by a car and his hip was broken. -She was not aware the resident was ordered Lovenox and was not getting the medication. -She expected Resident #1's medications to be administered as ordered. Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm revealed: -When Resident #1 was discharged from the hospital his medications were sent to the pharmacy. -When medications were sent to the pharmacy, the pharmacy usually filled, dispensed, and delivered the medications the same day. -On 04/28/21, the Administrator called the pharmacy and inquired about Resident #1's medications. -The Lovenox was delivered to the facility in the evening on 04/28/21.	C 330		

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C 330	Continued From page 27 -She had not administered the Lovenox because she did not know how to administer the medication. -She did not know Lovenox was a blood thinner and it was needed to prevent Resident #1 from developing a blood clot. -She had no reason or excuse why she did not contacted the pharmacy to inquire about Resident #1's medications before 04/28/21. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed: -She had been at the hospital with her family member and did not know Resident #1's medications were not administered as ordered. -She went to the facility on 04/28/21 and noticed the SIC had not called the pharmacy to inquire about Resident #1's medications. -She immediately called the pharmacy to request the medication orders to be filled. -The SIC should have called the pharmacy the first day Resident #1's medications were not delivered. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56 pm was unsuccessful. Based on observation, record review and interview, it was determined Resident #1 was not interviewable. b. Review of Resident #1's hospital discharge summary report dated 04/23/21 revealed there was an order for bacitracin ointment (used to prevent the growth of bacteria) apply twice daily for 10 days with instructions to discontinue bacitracin ointment on 05/03/21. Review of Resident #1's April MAR revealed there	C 330		

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was no entry for bacitracin ointment.

Observation of Resident #1's medications on hand at the facility on 04/29/21 at 11:56am revealed:
-Bacitracin ointment was available for administration.
-Review of the pharmacy printed label revealed bacitracin ointment was dispensed on 04/28/21.
-The bacitracin ointment container was unopened indicating the ointment had not been used.

Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed:
-An order for bacitracin ointment was received on 04/23/21.
-The pharmacy did not dispense the medication because Resident #1's medications had not been filled from their pharmacy for over one year.
-The facility did not request the ointment to be filled until 04/28/21.
-Bacitracin ointment was filled and dispensed on 04/28/21.

Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm revealed:
-Resident #1's order for bacitracin ointment was sent to the pharmacy on 04/23/21.
-She did not call to see why the medication had not been filled and delivered.
-On 04/28/21, the Administrator called the pharmacy and inquired about Resident #1's bacitracin ointment.

Telephone interview with the Administrator on 04/30/21 at 11:29am revealed:
-She went to the facility on 04/28/21 and noticed the SIC had not called and requested Resident #1's medications from the pharmacy.

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-She immediately called the pharmacy to request Resident #1's medication ordered from the 04/23/21 hospital discharge be filled.
-The SIC was supposed to contact the pharmacy after not getting Resident #1's medications the next day.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56 pm was unsuccessful.

Based on observation, record review, and interview, it was determined Resident #1 was not interviewable.

c. Review of Resident #1's hospital discharge summary report dated 04/23/21 revealed there was an order for polyethylene glycol powder (used to treat constipation) once daily for 5 days with instructions to stop on 04/28/21.

Review of Resident #1's April MAR revealed there was no entry for polyethylene glycol powder.

Observation of Resident #1's medications on hand at the facility on 04/29/21 at 11:56am revealed:
-Polyethylene glycol powder was available for administration and was dispensed on 04/28/21.
-The plastic container had a securely locked seal that had not been broken indicating polyethylene had not been administered.

Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed:
-An order for polyethylene glycol powder was received on 04/23/21.
-The pharmacy did not dispense polyethylene glycol powder until 04/28/21 because it had been

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a year since Resident #1's medications were filled from their pharmacy.
-The pharmacy was not sure if the orders were sent in error.
-On 04/28/21, "someone" from the facility called and requested polyethylene glycol powder to be filled.

Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm revealed:
-When medication orders were given to the pharmacy to be filled, the pharmacy usually filled and dispensed the medication the same day.
-The pharmacy delivered medications directly to the facility.
-Resident #1's order for polyethylene glycol powder was sent to the pharmacy on 04/23/21.
-Resident #1's order for polyethylene glycol powder was not delivered to the facility until yesterday, 04/28/21.
-She knew Resident #1's polyethylene glycol powder had not been delivered to the facility and she did not call to inquire why.
-She had no reason why she did not contact the pharmacy regarding dispensing Resident #1's polyethylene glycol powder.
-She was not aware the order for Resident #1's polyethylene glycol powder was only to be administered for 5 days after the discharge.

Telephone interview with the Administrator on 04/30/21 at 11:29am revealed:
-She went to the facility on 04/28/21 and noticed the SIC had not called and requested Resident #1's medications from the pharmacy.
-She immediately called the pharmacy to request Resident #1's medication ordered from the 04/23/21 hospital discharge be filled.
-The SIC was supposed to contact the pharmacy after not getting Resident #1's medications the

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next day.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56 pm was unsuccessful.

Based on observation, record review and interview, it was determined Resident #1 was not interviewable.

d. Review of Resident #1's hospital discharge summary report dated 04/23/21 revealed there was an order for acetaminophen 325mg (used to treat pain) every six hours for 15 days with instructions to stop acetaminophen on 05/08/21.

Review of Resident #1's April MAR revealed there was no entry for acetaminophen 325mg.

Observation of Resident #1's medications on hand at the facility on 04/29/21 at 11:56am revealed:
-Acetaminophen 325mg was available for administration.
-Acetaminophen 325mg was filled and dispensed on 04/28/21 for a quantity of 60 tablets with 57 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed:
-An order for acetaminophen 325mg was received on 04/23/21.
-The pharmacy did not dispense acetaminophen 325mg because no one at the facility called to request the medication be filled.
-On 04/28/21, "someone" from the facility called and requested acetaminophen 325mg to be filled.
-On 04/28/21, acetaminophen 325mg was dispensed and 60 tablets were delivered to the

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C 330	Continued From page 32 facility. Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm revealed: -Resident #1's order for acetaminophen 325mg was sent to the pharmacy on 04/23/21. -Resident #1's order for acetaminophen 325mg was not delivered to the facility until yesterday, 04/28/21. -She knew Resident #1's acetaminophen 325mg had not been delivered to the facility and she did not call to inquire why the medication was not delivered. -She had no reason or excuse why she did not contact the pharmacy regarding the dispensing Resident #1's acetaminophen 325mg. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed: -Resident #1 was hit by a car on 04/15/21 and ended up having surgery due to a broken hip. -On 04/28/21, she went to the facility and noticed Resident #1's medications were not delivered by the pharmacy. -She immediately called the pharmacy and requested Resident #1's medications be filled. -The SIC should have contacted the pharmacy to inquire about Resident #1's medication, after the first day the medications were not delivered. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56 pm was unsuccessful. Based on observation, record review and interview, it was determined Resident #1 was not interviewable. Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am.	C 330		

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C 330	Continued From page 33 2. Review of #3's current FL2 dated 10/22/20 revealed: -Diagnoses included schizoaffective disorder, acid reflux, neuropathic pain, depression, dysphonia, and benign prostatic hyperplasia. -Resident #3 was constantly disoriented. -There were no medications listed on the FL2. -There was a handwritten note on the FL2 to "see attached" documented under "Medications" on the FL2. -There was no medication list attached to the FL2. a. Review of Resident #3's previous FL2 dated 03/25/20 revealed: -There were orders for medications that included omeprazole 20mg once daily (used to treat acid reflux). Review of Resident #3's March 2021 medication administration record (MAR) revealed there was no entry for omeprazole 20mg once daily. Review of Resident #3's April 2021 MAR revealed: -There was an entry for omeprazole 20mg once daily scheduled for administration at 8:00am. -There was documentation on the MAR omeprazole 20mg was administered daily from 04/01/21 through 04/29/21 at 8:00am. Observation of Resident #3's medications on hand at the facility on 04/29/21 at 11:59am revealed omeprazole 20mg was not available for administration. Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/30/21 at 9:18am revealed:	C 330		

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C 330	Continued From page 34 -Resident #3's current medications included omeprazole 20mg once daily. -Resident #3 was ordered omeprazole 20mg once daily due to a diagnosis of acid reflux. -He expected omeprazole 20mg to be administered daily as ordered. Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed: -The pharmacy filled Resident #3's medications every month. -The last order the pharmacy received for omeprazole was dated 09/08/20. -The medication was last filled and dispensed on 03/30/21 for a quantity of 30 tablets. Telephone interview with the Supervisor-In-Charge (SIC) on 04/30/21 at 4:03pm revealed: -She administered Resident #3's medications daily. -If omeprazole was not available then it was not sent from the pharmacy. -She did not always document administration of medications on the MAR when she administered medications. -She was unable to recall the last time Resident #3 was administered omeprazole. Attempted interview with Resident #3 on 04/29/21 at 9:40am was unsuccessful. Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am. b. Review of Resident #3's previous FL2 dated 03/25/20 revealed there were orders for medications that included gabapentin 300mg twice daily (used to treat nerve pain).	C 330		

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C 330	Continued From page 35 Review of Resident #3's March 2021 medication administration record (MAR) revealed: -There was an entry for gabapentin 300mg twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation gabapentin 300mg was administered at 8:00am from 03/01/21 through 03/29/21. -There was no documentation gabapentin 300mg was administered at 8:00pm from 03/01/21 through 03/31/21. Review of Resident #3's April 2021 medication administration record (MAR) revealed: -There was an entry for gabapentin 300mg twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation gabapentin 300mg was administered at 8:00am from 04/01/21 through 04/29/21. -There was no documentation gabapentin 300mg was administered at 8:00pm 04/01/21 through 04/28/21. Observation of Resident #3's medications on hand on 04/29/21 at 11:59am revealed: -Gabapentin 300mg was available for administration. -Gabapentin 300mg was dispensed on 04/02/21 for a quantity of 60 tablets with 15 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed: -The order for gabapentin twice daily was dated 04/02/21. -Gabapentin was dispensed on 04/02/21 for a quantity of 60 tablets.	C 330		

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C 330	Continued From page 36 Telephone interview with the Supervisor-In-Charge (SIC) on 04/30/21 at 4:03pm revealed: -She administered Resident #3's medications daily. -She administered gabapentin twice daily. -She forgot to document administration of Resident #3's medications on the March and April MAR. Attempted interview with Resident #3 on 04/29/21 at 9:40am was unsuccessful. Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am. c. Review of Resident #3's previous FL2 dated 03/25/20 revealed there was an order for benztropine 1mg once daily (used to treat muscle spasms). Review of Resident #3's March 2021 medication administration record (MAR) revealed there was no entry for benztropine 1mg once daily. Review of Resident #3's April 2021 medication administration record (MAR) revealed: -There was an entry for benztropine 1mg once daily scheduled for administration at 8:00am. -There was no documentation benztropine 1mg was administered as scheduled at 8:00am from 04/01/21 through 04/29/21. Observation of Resident #3's medications on hand on 04/29/21 at 11:59am revealed: -Benztropine 1mg was available for administration. -Review of the prescription label; benztropine 1mg was dispensed on 04/26/21 for a quantity of	C 330		

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30 tablets.
-The bubble-packed container of benztropine 1mg was unopened with 30 benztropine 1mg tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed:
-The pharmacy filled Resident #3's benztropine every month.
-The last order received for benztropine was dated 09/17/20.
-The medication was last filled and dispensed on 04/26/21 for a quantity of 30 tablets.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/30/21 at 9:18am revealed:
-Resident #3's current medications included benztropine 1mg once daily.
-He expected Resident #3's medications to be administered as ordered.

Telephone interview with the Supervisor-In-Charge (SIC) on 04/30/21 at 4:03pm revealed:
-She was sure that she administered Resident #3's benztropine.
-She did not realize benztropine was not documented on the March 2021 MAR.
-She could not explain why she did not document the administration of benztropine 1mg on April 2021.
-She could not say why the bubble-packed container of benztropine was unopened with no medication administered.

Attempted interview with Resident #3 on 04/29/21 at 9:40am was unsuccessful.

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C 330	Continued From page 38 Refer to the telephone interview with the Administrator on 04/30/21 at 11:29am. _____ Telephone interview with the Administrator on 04/30/21 at 11:29am revealed: -She expected the SIC to administer medications as ordered. -If a medication was not available the SIC should contact the pharmacy and the resident's PCP. -She had not been checking to ensure medications were administered as ordered. -She expected the SIC to initial immediately after she administered a medication. -She had no idea what was going on with the SIC. -The facility had no system to check behind the SIC to ensure she documented medications as administered. _____ The facility failed to ensure medications were administered as ordered related to not administering medication to prevent the formation of blood clots which placed the resident at risk for a blood clot, not administering bacterial ointment which could increase the risk of infection of the surgical site, not administering a pain medication which could cause increased pain due to surgery from a broken hip, and not administering a laxative which could cause constipation and stomach discomfort (#1), not administering medication to reduce acid reflux which could cause stomach burning and irritation, not administering medication for nerve pain which could cause increased pain, numbness, and tingling, and not administering medication for muscle spasms which could cause muscle tension, tightness and severe pain (#3). This failure placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____	C 330		

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C 330	Continued From page 39 The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 30, 2021.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff documented the administration of medications immediately following the administration and observation of the resident taking the medication for 2 of 3 sampled residents (Residents #2 and #3). The findings are: 1. Review of Resident #2's current FL2 dated 12/26/20 revealed: -Diagnoses included hypertension, mild intellectual disability, schizoaffective disorder, and	C 341		

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ELSIE-DORIS FAMILY CARE HOME	306 CHERRYGROVE STREET DURHAM, NC 27703

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C 341	Continued From page 40	C 341		

hyperlipidemia.
-There were no medications listed on the FL2.
-There was a handwritten note "see attached list" under "Medications" on the FL2.
-There was no medication list attached to the FL2.

Review of Resident #2's April 2021 medication administration record (MAR) revealed:
-There was an entry for metoprolol 25mg twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered once daily at 8:00am 04/01/21 through 04/31/21 (actual documentation)
-There was no documentation metoprolol 25mg was administered at 8:00pm from 04/01/21 through 04/28/21.

Observation of Resident #2's medications on hand at the facility on 04/29/21 at 11:58am revealed:
-Metoprolol 25mg was available for administration.
-Metoprolol 25mg was filled on 04/05/21 and a quantity of 60 tablets was dispensed.
-There were 11 metoprolol 25mg tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:45am revealed:
-Resident #2's metoprolol 25mg was dispensed monthly since May 2020.
-The pharmacy printed the MARs for the facility but not every medication on the MAR was dispensed by the pharmacy.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 04/30/21 at

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C 341	Continued From page 41 4:37pm was unsuccessful. Attempted interview with Resident #2 on 04/29/21 at 9:38am was unsuccessful. Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm. Refer to the telephone interview with the Administrator on 04/29/21 at 11:29am. 2. Review of Resident #3's current FL2 dated 10/22/20 revealed: -Diagnoses included schizoaffective disorder, depression, and dysphoria. -There were no medications listed on the FL2. -There was handwritten documentation "see attachment" under the "medications" of the FL2. -There were no documents attached to the FL2. -There was no updated medication list in Resident #3's record. Review of Resident #3's March 2021 medication administration record (MAR) revealed: -There was an entry for gabapentin 300mg twice daily was scheduled for administration at 8:00am and 8:00pm. -There was documentation gabapentin 300mg was administered once daily at 8:00am. -There was no documentation gabapentin 300mg was administered at 8:00pm from 03/01/21 through 03/31/21. Review of Resident #3's April 2021 MAR revealed: -There was an entry for gabapentin 300mg twice daily schedule for administration at 8:00am and 8:00pm. -There was documentation gabapentin 300mg was administered once daily at 8:00am.	C 341		

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C 341	Continued From page 42 -There was no documentation gabapentin 300mg was administered at 8:00pm from 04/01/21 through 04/29/21. Observation of Resident #3's medications on hand at the facility on 04/29/21 at 11:59am revealed: -Gabapentin 300mg was available for administration. -Gabapentin 300mg was filled on 04/02/21 and a quantity of 60 tablets was dispensed. -There were 15 gabapentin 300mg tablets remaining. Telephone interview with Resident #3's Primary Care Provider (PCP) on 04/30/21 at 9:18am revealed Resident #3's current medications included gabapentin 300mg twice daily. Telephone interview with a representative from the facility's contracted pharmacy on 04/30/21 at 11:16am revealed: -Resident #3's gabapentin 300mg was cycle filled monthly. -The last order received for gabapentin 300mg twice daily was last filled and dispensed on 04/02/21 for a quantity of 60 tablets. Attempted interview with Resident #3 on 04/29/21 at 9:40am was unsuccessful. Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm. Refer to the telephone interview with the Administrator on 04/29/21 at 11:29am. _____ Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm. -"Honestly," she did not sign the MAR each time	C 341		

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C 341	Continued From page 43 she administered residents' medications. -She tried to quickly document on the MAR today (04/29/21) so she would not get in trouble. -She was aware that she had to document on the MAR each time a medication was administered. -Sometimes she forgot to document on the MAR. Telephone interview with the Administrator on 04/30/21 at 11:29am revealed: -She expected the SIC to document the administration of a resident's medication each time she administered a medication. -She did not know the SIC was not documenting as required. -She had not been at the facility lately.	C 341		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a retrievable record of controlled substances was maintained and reconciled accurately for 1 of 3 sampled residents (Resident #2) related to the administration of an anti-anxiety medication. The findings are: Review of Resident #2's current FL2 dated	C 367		

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C 367	Continued From page 44 12/26/20 revealed: -Diagnoses included schizoaffective disorder, mild intellectual disability, and hypertension. -There were no medication orders on the current FL2. -There was no order for clonazepam on the FL2 (a schedule IV narcotic used to treat anxiety). Review of Resident #2's January 2021 medication administration record (MAR) revealed: -There was an entry for clonazepam 1mg once daily scheduled for administration at 8:00am. -There was documentation clonazepam 1mg was administered once daily from 01/01/21 through 01/31/21. Review of Resident #2's January 2021 controlled substance count sheets (CSCS) revealed: -There was a printed pharmacy label for clonazepam 1mg attached to the top left side of the CSCS. -Clonazepam 1mg was dispensed on 03/26/21, but was documented as signed out from 01/01/21 through 01/31/21. -There was documentation for a total of 30 tablets dispensed on 03/26/21 on the CSCS. -The beginning date on the CSCS was on 01/01/21 with the count starting at 30 tablets. -The end date was on 01/31/21 with the count ending of 0 tablets, which was incorrect if clonazepam 1mg was administered based on the dispensing date on 03/26/21. -There was no consistent documentation with the correct month and date clonazepam 1mg was signed out. Review of Resident #2's February 2021 MAR revealed: -There was an entry for clonazepam 1mg once daily scheduled for administration at 8:00am.	C 367		

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C 367	Continued From page 45 -There was documentation clonazepam 1mg was administered once daily from 02/01/21 through 02/28/21. Review of Resident #2's February 2021 CSCS revealed: -There was a printed pharmacy label for clonazepam 1mg attached to the top left side of the CSCS. -Clonazepam 1mg was dispensed on 02/23/21 but documented as signed out from 02/01/21 through 02/28/21. -There was documentation for a total of 30 tablets dispensed on 02/23/21, on the CSCS. -The beginning date on the CSCS was on 02/01/21 with the count starting at 30 tablets. -The end date was on 02/28/21 with a count ending of 2 tablets remaining. -Based on the dispensing date on 02/23/21 and the quantity of 30 tablets dispensed, there should be 25 clonazepam tablets remaining resulting in 25 tablets unaccounted for. Review of Resident #2's March 2021 MAR revealed: -There was an entry for clonazepam 1mg once daily scheduled for administration at 8:00am. -There was documentation clonazepam 1mg was administered once daily from 03/01/21 through 03/30/21. Review of Resident #2's March 2021 CSCS revealed: -There was a printed pharmacy label for clonazepam 1mg attached to the top left side of the CSCS. -Clonazepam 1mg was dispensed on 12/18/20 for a total of 30 tablets. -Clonazepam 1mg was documented as signed out from 03/01/21 through 03/30/21 on the CSCS.	C 367		

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C 367	Continued From page 46 -There was documentation on the CSCS the beginning date was on 03/01/21 with the count starting at 30 tablets. -The end date was on 03/30/21 with a count ending of 1 tablet remaining. -Based on the dispensing date on 12/18/20 and documentation from 03/01/21 through 03/30/21, the accuracy of the CSCS could not be determined. Review of Resident #2's April 2021 MAR revealed: -There was an entry for clonazepam 1mg once daily scheduled for administration at 8:00am. -There was documentation clonazepam 1mg was administered once daily from 04/01/21 through 04/29/21. Review of Resident #2's April 2021 CSCS revealed: -There was a printed pharmacy label for clonazepam 1mg attached to the top left side of the CSCS. -Clonazepam 1mg was dispensed on 01/15/21 for a total of 30 tablets. -Clonazepam 1mg was documented as signed out from 04/01/21 through 04/290/21 on the CSCS. -There was documentation on the CSCS the beginning date was on 04/01/21 with the count starting at 30 tablets. -The end date on 04/30/21 was completed in advance with a count ending of 1 clonazepam tablet remaining. -Based on the dispensing date on 01/15/21 and documentation on the CSCS that clonazepam 1mg was signed out from 04/01/21 through 04/29/21, it could not be determined the month and date clonazepam was administered.	C 367		

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C 367	Continued From page 47 Observation of Resident #2's clonazepam 1mg on hand at the facility 04/29/21 at 11:58am revealed clonazepam was dispensed on 04/05/21 for 30 tablets with 5 clonazepam tablets remaining. Telephone interview with the facility's contracted pharmacy on 04/30/21 at 11:45am revealed: -Resident #2's clonazepam 1mg was dispensed monthly. -The pharmacy sent CSCS with each supply of clonazepam for documentation and accuracy purposes. -If the facility did not know how to complete the CSCS they should have called and asked for instructions. Interview with the Supervisor in Charge (SIC) on 04/29/21 at 12:55pm revealed: -"Honesty, I just completed these sheets today so I didn't get in trouble." -She knew she was supposed to document on the CSCS when she administered Resident #2's clonazepam. -She did not know how to complete the CSCS. -The Administrator had shown her how to complete the CSCS, but she got confused. -She had not asked for assistance from anyone but the Administrator for completing the CSCS form. Telephone interview with the Administrator on 04/30/21 at 11:41am revealed: -The SIC knew she was supposed to complete the CSCS when she administered Resident #2's clonazepam. -If the SIC did not understand how to complete the CSCS she should have asked for help instead of not documenting it. -The facility did not have a system of monitoring	C 367		

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C 367	Continued From page 48 the CSCS or MARs. -She trusted SIC to do her job and complete the necessary documentation when administering medications.	C 367		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to an anticoagulant injection, an antibiotic ointment, a pain medication and a powdered laxative (#1), a proton pump inhibitor, nerve pain and muscle spasms medications (#3).[Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].	C 914		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.	C992		

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C992	Continued From page 49 (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 2 sampled staff (Staff A) prior to hire. The findings are: Review of Staff A's, Supervisor-In-Charge (SIC),	C992		

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C992	Continued From page 50 personnel records revealed: -Staff A was hired on 07/10/15. -There was no documentation Staff A completed an examination and screening for the presence of controlled substances prior to hire. Interview with Staff A on 04/29/21 at 1:00pm revealed: -She thought that she completed a drug screen when she was hired. -She did not know where the paperwork was located. Interview with the Administrator on 04/30/21 at 11:45am revealed: -Staff A was the only staff who worked at the facility. -Staff A had been employed at the facility since 2015 and had completed a drug screening. -She did not know what Staff A had done with her drug screen results.	C992		